State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to:

California Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

PLEASE NOTE: Effective January 1, 2004, new law governing enrollment of providers in the Medi-Cal program resulted in a process for the Department of Health Services (Department) to more thoroughly review applicants applying to participate in the Medi-Cal program and established a new provisional provider status. In addition, it resulted in revisions to the provider enrollment application forms.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned. Due to the volume of applications received, program staff are unable to reply to a request for the status of an application in process. Therefore, please allow for the 180 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Information about the completion of enrollment forms is located on the Medi-Cal Web site at **www.medi-cal.ca.gov**.

It is your responsibility to report to the Department any modifications to information previously submitted within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHS 6209, revised 7/04) form. However, if you are reporting a change of ownership of 50 percent or more, or a change of business address, you must complete a new application package.

Enrollment forms are available at **www.medi-cal.ca.gov** or by contacting the Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the "Provider Enrollment" link. If you have any questions, please submit your inquiry in writing to the above address

Provider Enrollment Branch
Payment Systems Division

Enclosures

(Revised 10/04)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL ORTHOTIC AND PROSTHETICS PROVIDER APPLICATION

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application and requested documentation, a Medi-Cal Disclosure Statement (DHS 6207) and a Medi-Cal Provider Agreement (DHS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

Enrollment action requested (check all that apply). Enter the date you are completing the application.

"New provider"—the applicant is not currently enrolled with the Medi-Cal program and would like to have a Medi-Cal provider number issued.

For any of the following enrollment actions checked, please provide a current Medi-Cal provider number.

"Change of business address"—the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

"Additional business address"—the applicant is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

"Change of ownership"—there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

"Sale of assets (50 percent or more)"—fifty (50) percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

"New Taxpayer ID number"—a new Taxpayer Identification Number (TIN) is issued by the IRS.

"Cumulative change of 50 percent or more in ownership or control"—there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

"Add rendering provider"—add a rendering provider to a provider group applicant or an existing provider group. If this is a request to be added as a rendering provider to a provider group applicant, enter the provider group name. If this is a request to be added as a rendering provider to an existing provider group, enter that group provider number.

"Continued enrollment"—the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current Medi-Cal provider number(s).

Check the box labeled "I intend to use my current..." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51(b).

"Type of entity"—check (✓) the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. "Legal name"—the name listed with the Internal Revenue Service (IRS).
2. Enter the date of birth of the individual named in number 1.
3. Check (✓) the gender of the individual named in number 1.
4. Indicate whether the applicant or provider is a certified Orthotist. If so, provide the certificate number and attach a legible copy of the certificate as issued by the American Board for Certification In Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.

5. Indicate whether the applicant or provider is a certified Prosthetist. If so, provide the certificate number and attach a legible copy of the certificate as issued by the American Board for Certification in Orthotics and Prosthetics or the Board for Orthotist/Prosthetist Certification.
6. "Business name"—the name of the applicant or provider if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement number and effective date. Attach a legible copy of the recorded/stamped Ficitious Business Name Statement to the application.
7. "Business telephone number"—the primary business telephone number used at the business location. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
8. "Business address"—the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
9. "Pay-to address"—the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
10. "Mailing address"—the address at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
11. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
12. If the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. (See Privacy Statement on page 4.)
13. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 1. Attach a legible copy to the application.
14. Enter the Medicare billing number.
15. Enter the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
16. Enter any local business license or permit numbers for any city or county or city and county where you conduct your business and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
17. "Printed name of provider"—print the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer or government official when applying to the California Department of Health Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
18. Check (✓) the gender of the individual named in number 17.
19. Provide the driver's license or state-issued identification number and state of issuance of the individual named in number 17. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
20. Enter the date of birth of the individual named in number 17.
21. Enter the social security number of the individual named in number 17. (Optional—see Privacy Statement on page 4.)
22. An original signature of the individual named in number 17 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.
23. The application must be notarized by a Notary Public. The Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ Driver's license or state-issued identification card
- ❒ Fictitious Business Name Statement
- ❒ TIN verification
- ❒ Seller's Permit
- ❒ Applicable certification(s)
- ❒ Signed Medi-Cal Disclosure Statement (DHS 6207)
- ❒ Signed Medi-Cal Provider Agreement (DHS 6208)

MEDI-CAL ORTHOTICS AND PROSTHETICS PROVIDER APPLICATION

Important:
- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: California Department of Health Services
  Provider Enrollment Branch
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

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Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check all that apply)

Date

❒ New provider

For any of the following actions, include current Medi-Cal provider number: _____

❒ Change of business address
❒ Additional business address
❒ Change of ownership
❒ Sale of assets (50 percent or more)
❒ New Taxpayer ID number
❒ Cumulative change of 50 percent or more in ownership or control
❒ Add rendering provider to:
  ❒ Provider group applicant—group name: _____
  ❒ Existing provider group—specify group provider number(s):_____
  _____

❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)

❒ I intend to use my current Medi-Cal provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51(b).

Type of entity (check one)

❒ Sole proprietor
❒ Corporation:
  Corporate number: _____
  State incorporated: _____
❒ Partnership
❒ Limited liability company:
  Corporate number: _____
  State incorporated: _____
❒ Government
❒ Nonprofit
  Type of nonprofit:_____
❒ Other:_____

1. Legal name of applicant or provider (as listed with the IRS) (last) (first) (middle)

2. Date of birth

3. Gender ❒ Male ❒ Female

4. Are you a certified Orthotist? ❒ Yes ❒ No
If yes, certificate number (attach a legible copy):

5. Are you a certified Prosthetist? ❒ Yes ❒ No
If yes, certificate number (attach a legible copy):

6. Business name, if different

7. Business telephone number ( )

Is this a fictitious business name? ❒ Yes ❒ No

If yes, list the Fictitious Business Name Statement number

Effective date

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement.)

8. Business address (number, street)	City	County	State	Nine-digit ZIP code
9. Pay-to address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code
10. Mailing address (number, street, P.O. Box number)	City		State	Nine-digit ZIP code

11. Taxpayer Identification Number (TIN) (Attach a legible copy of the IRS form.)
__ __ – __ __ __ __ __ __ __

12. Social security number. If sole proprietor not using a TIN, you must disclose this number. (See Privacy Statement on page 4.)
__ __ __ – __ __ – __ __ __ __

13. Driver's license or state-issued identification number and state of issuance (attach a legible copy)

14. Medicare billing number

15. Seller's Permit number (attach a legible copy)

16. Any local business license numbers, permits (attach legible copies)

Information About Individual Signing This Application

17. Printed name of provider (last)	(first)	(middle)	18. Gender ❒ Male ❒ Female

19. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	20. Date of birth	21. Social security number (***Optional***—see Privacy Statement below.)
		___ ___ ___ – ___ ___ – ___ ___ ___ ___

22. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of provider	Title

Executed at: _____, _____ on _____
(City) (State) (Date)

23. Notary Public

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the California Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, (916) 323-1945.